Managed Care Program Annual Report (MCPAR) for Missouri: Mo HealthNet Managed Care Program

Due Date	Last edited	Edited By	Status
12/27/2022	12/30/2022	Danica Bialczyk	In progress

	Indicator	Response
	Exclusion of CHIP from MCPAR Enrollees in separate CHIP programs funded under Title XXI should not be reported in the MCPAR. Please check this box if the state is unable to remove information about Separate CHIP enrollees from its reporting on this program.	Selected

Section A: Program Information

Point of Contact

Number	Indicator	Response
A.1	**State name** Auto-populated from your account profile.	Missouri
A.2a	**Contact name**	Jay Carver, Danica Bialczyk

Number	Indicator	Response
	First and last name of the contact person. States that do not wish to list a specific individual on the report are encouraged to use a department or program-wide email address that will allow anyone with questions to quickly reach someone who can provide answers.	
A.2b	**Contact email address** Enter email address. Department or program-wide email addresses ok.	MHD.MCQUALITY@dss.mo.gov
A.3a	**Submitter name** CMS receives this data upon submission of this MCPAR report.	Not Answered
A.3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	Not Answered
A.4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	Not Answered

Reporting Period

Number	Indicator	Response
A.5a	**Reporting period start date**	07/01/2021

Number	Indicator	Response
	Auto-populated from report dashboard.	
A.5b	**Reporting period end date** Auto-populated from report dashboard.	06/30/2022
A.6	**Program name** Auto-populated from report dashboard.	Mo HealthNet Managed Care Program

Add plans (A.7)

	Indicator	Response
	Plan name	Healthy Blue Home State Health Plan UnitedHealthcare

Add BSS entities (A.8)

	Indicator	Response
	BSS entity name	Wipro Infocrossing

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

Number	Indicator	Response
B.I.1	**Statewide Medicaid enrollment** Enter the total number of individuals enrolled in Medicaid as of the first day of the last month of the reporting year. Include all FFS and managed care enrollees, and count each person only once, regardless of the delivery system(s) in which they are enrolled.	1,277,355
B.I.2	**Statewide Medicaid managed care enrollment** Enter the total, unduplicated number of individuals enrolled in any type of Medicaid managed care as of the first day of the last month of the reporting year. Include enrollees in all programs, and count each person only once, even if they are enrolled in more than one managed care program or more than one managed care plan.	793,776

Topic III. Encounter Data Report

Number	Indicator	Response
B.III.1	**Data validation entity** Select the state agency/division or contractor tasked with evaluating the validity of encounter data submitted by MCPs. Encounter data validation	State actuaries

Number	Indicator	Response
	includes verifying the accuracy, completeness, timeliness, and/or consistency of encounter data records submitted to the state by Medicaid managed care plans. Validation steps may include pre-acceptance edits and post-acceptance analyses. See Glossary in Excel Workbook for more information.	

Topic X: Program Integrity

Number	Indicator	Response
B.X.1	**Payment risks between the state and plans** Describe service-specific or other focused PI activities that the state conducted during the past year in this managed care program. Examples include analyses focused on use of long-term services and supports (LTSS) or prescription drugs or activities that focused on specific payment issues to identify, address, and prevent fraud, waste or abuse. Consider data analytics, reviews of under/overutilization, and other activities.	The state uses encounter data for federal reporting, rate setting and risk adjustment
B.X.2	**Contract standard for overpayments** Does the state allow plans to retain overpayments, require the return of overpayments, or	State has established a hybrid system

Number	Indicator	Response
	has established a hybrid system? Select one.	
B.X.3	**Location of contract provision stating overpayment standard** Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).	per contract language (2.37.8) "The Health Plan may recoup and retain overpayments made to providers that were self-reported by the provider or identified through the health plans investigation within timeframes determined by the state agency," Also, in section 2.38.6 "when the health plan identifies an overpayment received from the state agency the state agency must be notified and reimbursed within 30 calendar days of identification."
B.X.4	**Description of overpayment contract standard** Briefly describe the overpayment standard (for example, details on whether the state allows plans to retain overpayments, requires the plans to return overpayments, or administers a hybrid system) selected in indicator B.X.2.	per contract language (2.37.8) "The Health Plan may recoup and retain overpayments made to providers that were self-reported by the provider or identified through the health plans investigation within timeframes determined by the state agency," Also, in section 2.38.6 "when the health plan identifies an overpayment received from the state agency the state agency must be notified and reimbursed within 30 calendar days of identification"
B.X.5	**State overpayment reporting monitoring** Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting? The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment pieces (whether annually or promptly). This indicator is	The State has a division that investigates overpayments with MMAC Provider Review and the MCOs also track for overpayments.

Number	Indicator	Response
	asking the state how it monitors that reporting.	
B.X.6	**Changes in beneficiary circumstances** Describe how the state ensures timely and accurate reconciliation of enrollment files between the state and plans to ensure appropriate payments for enrollees experiencing a change in status (e.g., incarcerated, deceased, switching plans).	A daily 837-eligibility reconciliation file is sent to each health plan.
B.X.7a	**Changes in provider circumstances: Monitoring plans** Does the state monitor whether plans report provider “for cause” terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.	Yes **Changes in provider circumstances: Metrics** Yes **Changes in provider circumstances: Describe metric** Network access monitoring, as well as REST Indicator list, as well as MMAC Process for id'ing Providers not enrolled into MHD.
B.X.8a	**Federal database checks: Excluded person or entities** During the state's federal database checks, did the state find any person or entity excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM	No

Number	Indicator	Response
	or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.	
B.X.9a	**Website posting of 5 percent or more ownership control** Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to §455.104 and required by 42 CFR 438.602(g)(3).	No
B.X.10	**Periodic audits** If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, what is the link(s) to the audit results? Refer to 42 CFR 438.602(e).	Documents titled Missouri Encounter Data Triennial Audit Summary and Missouri Triennial Financial Audit at the following link - https://dss.mo.gov/mhd/mc/pages/quality-oversight.htm

Section C: Program-Level Indicators

Topic I: Program Characteristics

Number	Indicator	Response
C1.I.1	**Program contract** Enter the title and date of the contract between the state and plans participating in the managed care program.	MO HealthNet Managed Care Program
		12/30/2021
C1.I.2	**Contract URL** Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	https://dss.mo.gov/business-processes/managed-care/archive.htm
C1.I.3	**Program type** What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Managed Care Organization (MCO)
C1.I.4a	**Special program benefits** Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more. Only list the benefit type if it is a covered service as specified in a contract between the state and managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-service should not be listed here.	Behavioral health Dental Transportation

Number	Indicator	Response
C1.I.4b	**Variation in special benefits** What are any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter "N/A" if not applicable.	N/A
C1.I.5	**Program enrollment** Enter the total number of individuals enrolled in the managed care program as of the first day of the last month of the reporting year.	793,776
C1.I.6	**Changes to enrollment or benefits** Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year.	N/A

Topic III: Encounter Data Report

Number	Indicator	Response
C1.III.1	**Uses of encounter data** For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more. Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider	Rate setting Quality/performance measurement Monitoring and reporting Contract oversight Program integrity Policy making and decision support

Number	Indicator	Response
	who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).	
C1.III.2	**Criteria/measures to evaluate MCP performance** What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more. Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d).	Timeliness of initial data submissions Timeliness of data corrections Timeliness of data certifications Use of correct file formats Overall data accuracy (as determined through data validation)
C1.III.3	**Encounter data performance criteria contract language** Provide reference(s) to the contract section(s) that describe the criteria by which managed care plan performance on encounter data submission and correction will be measured. Use contract section references, not page numbers.	Contract section 2.27.5 e
C1.III.4	**Financial penalties contract language** Provide reference(s) to the contract section(s) that	Contract section 2.27.5 c, and 2.27.5 d

Number	Indicator	Response
	describes any financial penalties the state may impose on plans for the types of failures to meet encounter data submission and quality standards. Use contract section references, not page numbers.	
C1.III.5	**Incentives for encounter data quality** Describe the types of incentives that may be awarded to managed care plans for encounter data quality. Reply with "N/A" if the plan does not use incentives to award encounter data quality.	N/A
C1.III.6	**Barriers to collecting/validating encounter data** Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting period.	Covid Pandemic, Errors with systems coding encounters

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
C1.IV.1	**State's definition of "critical incident," as used for reporting purposes in its MLTSS program** If this report is being completed for a managed care program	N/A

Number	Indicator	Response
	that covers LTSS, what is the definition that the state uses for "critical incidents" within the managed care program? Respond with "N/A" if the managed care program does not cover LTSS.	
C1.IV.2	**State definition of "timely" resolution for standard appeals** Provide the state's definition of timely resolution for standard appeals in the managed care program. Per 42 CFR §438.408(b)(2), states must establish a timeframe for timely resolution of standard appeals that is no longer than 30 calendar days from the day the MCO, PIHP or PAHP receives the appeal.	Per MCO Contract, Section 2.16.6 (f) - The health plan shall inform the member of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in 42 C.F.R 438.408(b) and © in the case of expedited resolution.
C1.IV.3	**State definition of "timely" resolution for expedited appeals** Provide the state's definition of timely resolution for expedited appeals in the managed care program. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal.	Per MCO Contract, Section 2.13.16(21) - For expedited resolution - within three business days from the state agency's receipt of a state fair hearing request for denial of service that meets the criteria for an expedited appeal process but was not resolved using the health plan's expedited appeal timeframes or was resolved wholly or partially adversely to the member using the health plan's expedited appeal process. Additionally, Per Contract section 2.16.6(L) does establish the 30-calendar-day limit as required. I like the answer that is currently entered, but think that it should also clarify that the contract includes the require timeframe
C1.IV.4	**State definition of "timely" resolution for grievances**	Per MCO Contract, Section 2.13.16(21) - for standard resolution - within 90 calendar days from the state agency's receipt of a state fair hearing request. Additionally, per contract

Number	Indicator	Response
	Provide the state's definition of timely resolution for grievances in the managed care program. Per 42 CFR §438.408(b)(1), states must establish a timeframe for timely resolution of grievances that is no longer than 90 calendar days from the day the MCO, PIHP or PAHP receives the grievance.	section 2.16.5e, for grievances (not state fair hearings), this timeframe is 30 calendar days

Topic V. Availability, Accessibility and Network Adequacy

Number	Indicator	Response
C1.V.1	**Gaps/challenges in network adequacy** What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting standards.	Number of available providers statewide; providers willing to contract with MCO's to serve medicaid members.
C1.V.2	**State response to gaps in network adequacy** How does the state work with MCPs to address gaps in network adequacy?	Upon identification of network gaps the state provides MCO's with information of available providers to outreach. If there are not available providers the state allows exceptions to travel distance standards. MCOs are required to ensure members receive covered services by out-of-network providers at no greater cost to the enrollee than for access to an in-network provider if access to an in-network provider cannot be assured without unreasonable delay.

Topic V. Availability, Accessibility and Network Adequacy

Access Measures

Describe the measures the state uses to monitor availability, accessibility, and network adequacy. Report at the program level.

Revisions to the Medicaid managed care regulations in 2016 and 2020 built on existing requirements that managed care plans maintain provider networks sufficient to ensure adequate access to covered services by: (1) requiring states to develop quantitative network adequacy standards for at least eight specified provider types if covered under the contract, and to make these standards available online; (2) strengthening network adequacy monitoring requirements; and (3) addressing the needs of people with long-term care service needs (42 CFR 438.66; 42 CFR 438.68).

42 CFR 438.66(e) specifies that the MCPAR must provide information on and an assessment of the availability and accessibility of covered services within the MCO, PHIP, or PAHP contracts, including network adequacy standards for each managed care program.

Find in the Excel Workbook
C2_Program_State

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard 1 / 44

C2.V.2 Measure standard

90% of members must have access to one primary care provider based on county classification: 10 miles - urban, 20 miles - basic, 30 miles - rural

C2.V.1 General category

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Statewide Urban, Basic, Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Plan provider roster review, Review of grievances related to access, Provider terminations from the network

C2.V.8 Frequency of oversight methods

At procurement, Annually, or anytime a provider terminates from the network that could decrease access below 90% for a specific area and provider type.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

2 / 44

C2.V.2 Measure standard

90% of members must have access to one primary care provider based on county classification: 15 miles - urban, 30 miles - basic, 60 miles - rural

C2.V.1 General category

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Physicians, Obstetric/Gynecology	Statewide Urban, Basic, Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Plan provider roster review, Provider terminations from the network

C2.V.8 Frequency of oversight methods

At procurement, Annually, or anytime a provider terminates from the network that could decrease access below 90% for a specific area and provider type.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

90% of members must have access to one primary care provider based on county classification: 25 miles - urban, 50 miles - basic, 100 miles - rural

C2.V.1 General category

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Physicians, Neurology	Statewide Urban, Basic, Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Plan provider roster review, Provider terminations from the network

C2.V.8 Frequency of oversight methods

At procurement, Annually, or anytime a provider terminates from the network that could decrease access below 90% for a specific area and provider type.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

90% of members must have access to one primary care provider based on county classification: 25 miles - urban, 50 miles - basic, 100 miles - rural

C2.V.1 General category

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Physicians, Dermatology	Statewide Urban, Basic, Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Plan provider roster review, Provider terminations from the network

C2.V.8 Frequency of oversight methods

At procurement, Annually, or anytime a provider terminates from the network that could decrease access below 90% for a specific area and provider type.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

90% of members must have access to one primary care provider based on county classification: 25 miles - urban, 50 miles - basic, 100 miles - rural

C2.V.1 General category

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population

Physicians, Physical Medicine/Rehab	Statewide Urban, Basic, Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Plan provider roster review, Provider terminations from the network

C2.V.8 Frequency of oversight methods

At procurement, Annually, or anytime a provider terminates from the network that could decrease access below 90% for a specific area and provider type.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

90% of members must have access to one primary care provider based on county classification: 25 miles - urban, 50 miles - basic, 100 miles - rural

C2.V.1 General category

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Physicians, Podiatry	Statewide Urban, Basic, Rural	Adult

C2.V.7 Monitoring Methods

Geomapping, Plan provider roster review, Provider terminations from the network

C2.V.8 Frequency of oversight methods

At procurement, Annually, or anytime a provider terminates from the network that could decrease access below 90% for a specific area and provider type.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

90% of members must have access to one primary care provider based on county classification: 15 miles - urban, 30 miles - basic, 60 miles - rural

C2.V.1 General category

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Physicians, Vision Care/ Primary Eye Care	Statewide Urban, Basic, Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Plan provider roster review, Provider terminations from the network

C2.V.8 Frequency of oversight methods

At procurement, Annually, or anytime a provider terminates from the network that could decrease access below 90% for a specific area and provider type.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

90% of members must have access to one primary care provider based on county classification: 25 miles - urban, 50 miles - basic, 100 miles - rural

C2.V.1 General category

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Physicians, Allergy	Statewide Urban, Basic, Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Plan provider roster review, Provider terminations from the network

C2.V.8 Frequency of oversight methods

At procurement, Annually, or anytime a provider terminates from the network that could decrease access below 90% for a specific area and

provider type.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

90% of members must have access to one primary care provider based on county classification: 25 miles - urban, 50 miles - basic, 100 miles - rural

C2.V.1 General category

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Physicians, Cardiology	Statewide Urban, Basic, Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Plan provider roster review, Provider terminations from the network

C2.V.8 Frequency of oversight methods

At procurement, Annually, or anytime a provider terminates from the network that could decrease access below 90% for a specific area and provider type.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

90% of members must have access to one primary care provider based on county classification: 25 miles - urban, 50 miles - basic, 100 miles - rural

C2.V.1 General category

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Physicians, Endocrinology	Statewide Urban, Basic, Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Plan provider roster review, Provider terminations from the network

C2.V.8 Frequency of oversight methods

At procurement, Annually, or anytime a provider terminates from the network that could decrease access below 90% for a specific area and provider type.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

90% of members must have access to one primary care provider based on county classification: 25 miles - urban, 50 miles - basic, 100 miles - rural

C2.V.1 General category

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Physicians, Gastroenterology	Statewide Urban, Basic, Rural	Adult

C2.V.7 Monitoring Methods

Geomapping, Plan provider roster review, Provider terminations from the network

C2.V.8 Frequency of oversight methods

At procurement, Annually, or anytime a provider terminates from the network that could decrease access below 90% for a specific area and provider type.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

90% of members must have access to one primary care provider based on county classification: 25 miles - urban, 50 miles - basic, 100 miles - rural

C2.V.1 General category

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Physicians, Hematology/Omcology	Statewide Urban, Basic, Rural	Adult

C2.V.7 Monitoring Methods

Geomapping, Plan provider roster review, Provider terminations from the network

C2.V.8 Frequency of oversight methods

At procurement, Annually, or anytime a provider terminates from the network that could decrease access below 90% for a specific area and provider type.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

90% of members must have access to one primary care provider based on county classification: 25 miles - urban, 50 miles - basic, 100 miles - rural

C2.V.1 General category

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Physicians, Infectious Disease	Statewide Urban, Basic, Rural	Adult

C2.V.7 Monitoring Methods

Geomapping, Plan provider roster review, Provider terminations from the network

C2.V.8 Frequency of oversight methods

At procurement, Annually, or anytime a provider terminates from the network that could decrease access below 90% for a specific area and provider type.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

90% of members must have access to one primary care provider based on county classification: 25 miles - urban, 50 miles - basic, 100 miles - rural

C2.V.1 General category

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Physicians, Nephrology	Statewide Urban, Basic, Rural	Adult

C2.V.7 Monitoring Methods

Geomapping, Plan provider roster review, Provider terminations from the network

C2.V.8 Frequency of oversight methods

At procurement, Annually, or anytime a provider terminates from the network that could decrease access below 90% for a specific area and provider type.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

90% of members must have access to one primary care provider based on county classification: 25 miles - urban, 50 miles - basic, 100 miles - rural

C2.V.1 General category

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Physicians, Ophthalmology	Statewide Urban, Basic, Rural	Adult

C2.V.7 Monitoring Methods

Geomapping, Plan provider roster review, Provider terminations from the network

C2.V.8 Frequency of oversight methods

At procurement, Annually, or anytime a provider terminates from the network that could decrease access below 90% for a specific area and provider type.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

90% of members must have access to one primary care provider based on county classification: 25 miles - urban, 50 miles - basic, 100 miles - rural

C2.V.1 General category

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Physicians, Orthopedics	Statewide Urban, Basic, Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Plan provider roster review, Provider terminations from the network

C2.V.8 Frequency of oversight methods

At procurement, Annually, or anytime a provider terminates from the network that could decrease access below 90% for a specific area and provider type.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

90% of members must have access to one primary care provider based on county classification: 25 miles - urban, 50 miles - basic, 100 miles - rural

C2.V.1 General category

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population

Physicians, Otolaryngology	Statewide Urban, Basic, Rural	Adult

C2.V.7 Monitoring Methods

Geomapping, Plan provider roster review, Provider terminations from the network

C2.V.8 Frequency of oversight methods

At procurement, Annually, or anytime a provider terminates from the network that could decrease access below 90% for a specific area and provider type.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

90% of members must have access to one primary care provider based on county classification: 25 miles - urban, 50 miles - basic, 100 miles - rural

C2.V.1 General category

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Physicians, Pediatric	Statewide Urban, Basic, Rural	Pediatric

C2.V.7 Monitoring Methods

Geomapping, Plan provider roster review, Provider terminations from the network

C2.V.8 Frequency of oversight methods

At procurement, Annually, or anytime a provider terminates from the network that could decrease access below 90% for a specific area and provider type.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

90% of members must have access to one primary care provider based on county classification: 25 miles - urban, 50 miles - basic, 100 miles - rural

C2.V.1 General category

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Physicians, Pulmonary Disease	Statewide Urban, Basic, Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Plan provider roster review, Provider terminations from the network

C2.V.8 Frequency of oversight methods

At procurement, Annually, or anytime a provider terminates from the network that could decrease access below 90% for a specific area and provider type.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

90% of members must have access to one primary care provider based on county classification: 25 miles - urban, 50 miles - basic, 100 miles - rural

C2.V.1 General category

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Physicians, Rheumatology	Statewide Urban, Basic, Rural	Adult

C2.V.7 Monitoring Methods

Geomapping, Plan provider roster review, Provider terminations from the network

C2.V.8 Frequency of oversight methods

At procurement, Annually, or anytime a provider terminates from the network that could decrease access below 90% for a specific area and provider type.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

90% of members must have access to one primary care provider based on county classification: 25 miles - urban, 50 miles - basic, 100 miles - rural

C2.V.1 General category

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Physicians, Urology	Statewide Urban, Basic, Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Plan provider roster review, Provider terminations from the network

C2.V.8 Frequency of oversight methods

At procurement, Annually, or anytime a provider terminates from the network that could decrease access below 90% for a specific area and provider type.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

90% of members must have access to one primary care provider based on county classification: 15 miles - urban, 30 miles - basic, 60 miles - rural

C2.V.1 General category

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
		Adult and pediatric

Physicians, General Surgery	Statewide Urban, Basic, Rural

C2.V.7 Monitoring Methods

Plan provider roster review, Geomapping, Provider terminations from the network

C2.V.8 Frequency of oversight methods

At procurement, Annually, or anytime a provider terminates from the network that could decrease access below 90% for a specific area and provider type.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

23 / 44

C2.V.2 Measure standard

90% of members must have access to one primary care provider based on county classification: 15 miles - urban, 40 miles - basic, 80 miles - rural

C2.V.1 General category

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Physicians, Psychiatrist Adult/General	Statewide Urban, Basic, Rural	Adult

C2.V.7 Monitoring Methods

Geomapping, Plan provider roster review, Provider terminations from the network

C2.V.8 Frequency of oversight methods

At procurement, Annually, or anytime a provider terminates from the network that could decrease access below 90% for a specific area and provider type.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

24 / 44

C2.V.2 Measure standard

90% of members must have access to one primary care provider based on county classification: 22 miles - urban, 45 miles - basic, 90 miles - rural

C2.V.1 General category

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Physicians, Psychiatrist - Child/Adolescent	Statewide Urban, Basic, Rural	Pediatric

C2.V.7 Monitoring Methods

Geomapping, Plan provider roster review, Provider terminations from the network

C2.V.8 Frequency of oversight methods

At procurement, Annually, or anytime a provider terminates from the network that could decrease access below 90% for a specific area and provider type.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

25 / 44

C2.V.2 Measure standard

90% of members must have access to one primary care provider based on county classification: 10 miles - urban, 20 miles - basic, 40 miles - rural

C2.V.1 General category

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Physicians, Psychologists/Other Therapists	Statewide Urban, Basic, Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Plan provider roster review, Provider terminations from the network

C2.V.8 Frequency of oversight methods

At procurement, Annually, or anytime a provider terminates from the network that could decrease access below 90% for a specific area and provider type.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

26 / 44

C2.V.2 Measure standard

90% of members must have access to one primary care provider based on county classification: 15 miles - urban, 30 miles - basic, 60 miles - rural

C2.V.1 General category

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Physicians, Chiropractor	Statewide Urban, Basic, Rural	Adult

C2.V.7 Monitoring Methods

Geomapping, Plan provider roster review, Provider terminations from the network

C2.V.8 Frequency of oversight methods

At procurement, Annually, or anytime a provider terminates from the network that could decrease access below 90% for a specific area and provider type.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

27 / 44

C2.V.2 Measure standard

90% of members must have access to one primary care provider based on county classification: 30 miles - urban, 30 miles - basic, 30 miles - rural

C2.V.1 General category

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
		Adult and pediatric

Hospital, Basic Hospital	Statewide Urban, Basic, Rural

C2.V.7 Monitoring Methods

Geomapping, Plan provider roster review, Provider terminations from the network

C2.V.8 Frequency of oversight methods

At procurement, Annually, or anytime a provider terminates from the network that could decrease access below 90% for a specific area and provider type.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

28 / 44

C2.V.2 Measure standard

90% of members must have access to one primary care provider based on county classification: 50 miles - urban, 50 miles - basic, 50 miles - rural

C2.V.1 General category

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Hospital, Secondary Hospital	Statewide Urban, Basic, Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Plan provider roster review, Provider terminations from the network

C2.V.8 Frequency of oversight methods

At procurement, Annually, or anytime a provider terminates from the network that could decrease access below 90% for a specific area and provider type.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

29 / 44

C2.V.2 Measure standard

90% of members must have access to one primary care provider based on county classification: 100 miles - urban, 100 miles - basic, 100 miles - rural

C2.V.1 General category

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Tertiary Services, Level I or Level II Trauma Unit	Statewide Urban, Basic, Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Plan provider roster review, Provider terminations from the network

C2.V.8 Frequency of oversight methods

At procurement, Annually, or anytime a provider terminates from the network that could decrease access below 90% for a specific area and provider type.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

30 / 44

C2.V.2 Measure standard

90% of members must have access to one primary care provider based on county classification: 100 miles - urban, 100 miles - basic, 100 miles - rural

C2.V.1 General category

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Tertiary Services, Neonatal intensive care unit	Statewide Urban, Basic, Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Plan provider roster review, Provider terminations from the network

C2.V.8 Frequency of oversight methods

At procurement, Annually, or anytime a provider terminates from the network that could decrease access below 90% for a specific area and provider type.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

31 / 44

C2.V.2 Measure standard

90% of members must have access to one primary care provider based on county classification: 100 miles - urban, 100 miles - basic, 100 miles - rural

C2.V.1 General category

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Tertiary Services, Perinatology services	Statewide Urban, Basic, Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Plan provider roster review, Provider terminations from the network

C2.V.8 Frequency of oversight methods

At procurement, Annually, or anytime a provider terminates from the network that could decrease access below 90% for a specific area and provider type.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

32 / 44

C2.V.2 Measure standard

90% of members must have access to one primary care provider based on county classification: 100 miles - urban, 100 miles - basic, 100 miles - rural

C2.V.1 General category

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
		Adult and pediatric

Tertiary Services, Comprehensive cancer services	Statewide Urban, Basic, Rural

C2.V.7 Monitoring Methods

Geomapping, Plan provider roster review, Provider terminations from the network

C2.V.8 Frequency of oversight methods

At procurement, Annually, or anytime a provider terminates from the network that could decrease access below 90% for a specific area and provider type.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

33 / 44

C2.V.2 Measure standard

90% of members must have access to one primary care provider based on county classification: 100 miles - urban, 100 miles - basic, 100 miles - rural

C2.V.1 General category

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Tertiary Services, Comprehensive cardiac services	Statewide Urban, Basic, Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Plan provider roster review, Provider terminations from the network

C2.V.8 Frequency of oversight methods

At procurement, Annually, or anytime a provider terminates from the network that could decrease access below 90% for a specific area and provider type.

C2.V.3 Standard type: General quantitative availability and accessibility standard

34 / 44

Complete

C2.V.2 Measure standard

90% of members must have access to one primary care provider based on county classification: 100 miles - urban, 100 miles - basic, 100 miles - rural

C2.V.1 General category

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Tertiary Services, Pediatric Subspecialty care	Statewide Urban, Basic, Rural	Pediatric

C2.V.7 Monitoring Methods

Geomapping, Plan provider roster review, Provider terminations from the network

C2.V.8 Frequency of oversight methods

At procurement, Annually, or anytime a provider terminates from the network that could decrease access below 90% for a specific area and provider type.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

35 / 44

C2.V.2 Measure standard

90% of members must have access to one primary care provider based on county classification: 25 miles - urban, 40 miles - basic, 75 miles - rural

C2.V.1 General category

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Mental Health Facilities, Inpatient mental health treatment facility	Statewide Urban, Basic, Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Plan provider roster review, Provider terminations from the network

C2.V.8 Frequency of oversight methods

At procurement, Annually, or anytime a provider terminates from the network that could decrease access below 90% for a specific area and provider type.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

36 / 44

C2.V.2 Measure standard

90% of members must have access to one primary care provider based on county classification: 15 miles - urban, 25 miles - basic, 45 miles - rural

C2.V.1 General category

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Mental Health Facilities, Ambulatory mental health treatment providers	Statewide Urban, Basic, Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Plan provider roster review, Provider terminations from the network

C2.V.8 Frequency of oversight methods

At procurement, Annually, or anytime a provider terminates from the network that could decrease access below 90% for a specific area and provider type.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

37 / 44

C2.V.2 Measure standard

90% of members must have access to one primary care provider based on county classification: 20 miles - urban, 30 miles - basic, 50 miles - rural

C2.V.1 General category

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Mental Health Facilites, Residential mental health treatment providers	Statewide Urban, Basic, Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Plan provider roster review, Provider terminations from the network

C2.V.8 Frequency of oversight methods

At procurement, Annually, or anytime a provider terminates from the network that could decrease access below 90% for a specific area and provider type.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

38 / 44

C2.V.2 Measure standard

90% of members must have access to one primary care provider based on county classification: 30 miles - urban, 30 miles - basic, 30 miles - rural

C2.V.1 General category

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Auxiliary Services, Physical Therapy	Statewide Urban, Basic, Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Plan provider roster review, Provider terminations from the network

C2.V.8 Frequency of oversight methods

At procurement, Annually, or anytime a provider terminates from the network that could decrease access below 90% for a specific area and provider type.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

39 / 44

C2.V.2 Measure standard

90% of members must have access to one primary care provider based on county classification: 30 miles - urban, 30 miles - basic, 30 miles - rural

C2.V.1 General category

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Auxiliary Services, Occupational Therapy	Statewide Urban, Basic, Rural	Adult

C2.V.7 Monitoring Methods

Geomapping, Plan provider roster review, Provider terminations from the network

C2.V.8 Frequency of oversight methods

At procurement, Annually, or anytime a provider terminates from the network that could decrease access below 90% for a specific area and provider type.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

40 / 44

C2.V.2 Measure standard

90% of members must have access to one primary care provider based on county classification: 50 miles - urban, 50 miles - basic, 50 miles - rural

C2.V.1 General category

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Auxiliary Services, Speech Therapy	Statewide Urban, Basic, Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Plan provider roster review, Provider terminations from the network

C2.V.8 Frequency of oversight methods

At procurement, Annually, or anytime a provider terminates from the network that could decrease access below 90% for a specific area and provider type.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

41 / 44

C2.V.2 Measure standard

90% of members must have access to one primary care provider based on county classification: 50 miles - urban, 50 miles - basic, 50 miles - rural

C2.V.1 General category

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Auxiliary Services, Audiology	Statewide Urban, Basic, Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Plan provider roster review, Provider terminations from the network

C2.V.8 Frequency of oversight methods

At procurement, Annually, or anytime a provider terminates from the network that could decrease access below 90% for a specific area and provider type.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

42 / 44

C2.V.2 Measure standard

Increase the percentage of Primary Care Provider offices that met the urgent appointment standard (24 hours for illness or Injury requiring immediate care).

C2.V.1 General category

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly review of grievances related to access. Annual Secret shopper survey conducted by EQRO.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

43 / 44

C2.V.2 Measure standard

Increase the percentage of Primary Care Provider offices that met the urgent appointment standard (30 days for routine care without symptoms).

C2.V.1 General category

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly monitoring of grievances. Annual Secret Shopper survey conducted by EQRO.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

44 / 44

C2.V.2 Measure standard

Increase the percentage of psychiatrist offices that met the two-week appointment standard for routine behavioral health and substance use

services without symptoms.

C2.V.1 General category

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly monitoring of grievances. Annual Secret Shopper survey conducted by EQRO.

Topic IX: Beneficiary Support System (BSS)

Number	Indicator	Response
C1.IX.1	**BSS website** List the website(s) and/or email address that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.	https://apps.dss.mo.gov/mhdOnlineEnroll/ and https://dss.mo.gov/mhd/healthcare-benefit.htm
C1.IX.2	**BSS auxiliary aids and services** How do BSS entities offer services in a manner that is accessible to all beneficiaries who need their services, including beneficiaries with disabilities, as required by 42 CFR 438.71(b)(2))? CFR 438.71 requires that the beneficiary support system be accessible in multiple ways including phone, Internet, in-	• Requesting a change online (you will need your PIN number and MO HealthNet ID Number) • Calling 800-348-6627 (TTY: 711) between 7 a.m. and 6 p.m. Monday through Friday • Mailing your signed and completed change form(s) to: MO HealthNet Division PO Box 104928 Jefferson City, MO 65110 If you have questions or need help choosing a new health plan, please call 800-348-6627. Our team can help between 7 a.m. and 6 p.m. Monday through Friday. Translation services are also available at no cost. If you are deaf or hearing impaired, please call Relay Missouri at 711 for help.

Number	Indicator	Response
	person, and via auxiliary aids and services when requested.	
C1.IX.3	**BSS LTSS program data** How do BSS entities assist the state with identifying, remediating, and resolving systemic issues based on a review of LTSS program data such as grievances and appeals or critical incident data? Refer to 42 CFR 438.71(d)(4).	per the 1915(b) waiver, the enrollment broker does not provide assistance with LTSS.
C1.IX.4	**State evaluation of BSS entity performance** What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?	The state agency reviews monthly reports received from the contractor. Upon any issue arising from an action the contractor has taken, the recorded call is pulled and, if necessary, education/re-education is provided to the contractor to ensure quality and accuracy is met.

Topic X: Program Integrity

Number	Indicator	Response
C1.X.3	**Prohibited affiliation disclosure** Did any plans disclose prohibited affiliations? If the state took action, enter those actions under D: Plan-level Indicators, Section VIII - Sanctions (Corresponds with Tab D3 in the Excel Workbook). Refer to 42 CFR 438.610(d).	No

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D1.I.1	**Plan enrollment** What is the total number of individuals enrolled in each plan as of the first day of the last month of the reporting year?	**Healthy Blue** 301,253 **Home State Health Plan** 264,986 **UnitedHealthcare** 227,537
D1.I.2	**Plan share of Medicaid** What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid enrollment (B.I.1)	**Healthy Blue** 24% **Home State Health Plan** 21% **UnitedHealthcare** 18%
D1.I.3	**Plan share of any Medicaid managed care** What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid managed care enrollment (B.I.2)	**Healthy Blue** 38% **Home State Health Plan** 33% **UnitedHealthcare** 29%

Topic II. Financial Performance

Number	Indicator	Response
D1.II.1a	**Medical Loss Ratio (MLR)** What is the MLR percentage? Per 42 CFR 438.66(e)(2)(i), the Managed Care Program Annual Report must provide information on the Financial performance of each MCO, PIHP, and PAHP, including MLR experience. If MLR data are not available for this reporting period due to data lags, enter the MLR calculated for the most recently available reporting period and indicate the reporting period in item D1.II.3 below. See Glossary in Excel Workbook for the regulatory definition of MLR.	**Healthy Blue** 84.8% **Home State Health Plan** 80.9% **UnitedHealthcare** 84.9%
D1.II.1b	**Level of aggregation** What is the aggregation level that best describes the MLR being reported in the previous indicator? Select one. As permitted under 42 CFR 438.8(i), states are allowed to aggregate data for reporting purposes across programs and populations.	**Healthy Blue** Statewide all programs & populations **Home State Health Plan** Statewide all programs & populations **UnitedHealthcare** Statewide all programs & populations
D1.II.2	**Population specific MLR description** Does the state require plans to submit separate MLR calculations for specific populations served within this program, for example, MLTSS	**Healthy Blue** N/A **Home State Health Plan** N/A

Number	Indicator	Response
	or Group VIII expansion enrollees? If so, describe the populations here. Enter "N/A" if not applicable. See glossary for the regulatory definition of MLR.	**UnitedHealthcare** N/A
D1.II.3	**MLR reporting period discrepancies** Does the data reported in item D1.II.1a cover a different time period than the MCPAR report?	**Healthy Blue** Yes 07/01/2020 06/30/2021 **Home State Health Plan** Yes 07/01/2020 06/30/2021 **UnitedHealthcare** Yes 07/01/2020 06/30/2021

Topic III. Encounter Data

Number	Indicator	Response
D1.III.1	**Definition of timely encounter data submissions** Describe the state's standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of encounter within this program, please explain.	**Healthy Blue** Encounters must be submitted within 30 days of the day the health plan pays the claim and must be received within 2 years from LDOS **Home State Health Plan** Encounters must be submitted within 30 days of the day the health plan pays the claim and must be received within 2 years from LDOS **UnitedHealthcare** Encounters must be submitted within 30 days of the day the health plan pays the claim and must be received within 2 years from LDOS

Number	Indicator	Response
D1.III.2	**Share of encounter data submissions that met state's timely submission requirements** What percent of the plan's encounter data file submissions (submitted during the reporting period) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract period when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting period.	**Healthy Blue** 99.25% **Home State Health Plan** 99.99% **UnitedHealthcare** 99.56%
D1.III.3	**Share of encounter data submissions that were HIPAA compliant** What percent of the plan's encounter data submissions (submitted during the reporting period) met state requirements for HIPAA compliance? If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion received from the managed care plan for the reporting period.	**Healthy Blue** 99.12% **Home State Health Plan** 98.22% **UnitedHealthcare** 98.84%

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
D1.IV.1	**Appeals resolved (at the plan level)** Enter the total number of appeals resolved as of the first day of the last month of the reporting year. An appeal is "resolved" at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary's representative) chooses to file a request for a State Fair Hearing or External Medical Review.	**Healthy Blue** 5,307 **Home State Health Plan** 2,427 **UnitedHealthcare** 4,079
D1.IV.2	**Active appeals** Enter the total number of appeals still pending or in process (not yet resolved) as of the first day of the last month of the reporting year.	**Healthy Blue** 730 **Home State Health Plan** 227 **UnitedHealthcare** 392
D1.IV.3	**Appeals filed on behalf of LTSS users** Enter the total number of appeals filed during the reporting year by or on behalf of LTSS users. Enter “N/A” if not applicable.	**Healthy Blue** 0 **Home State Health Plan** 0 **UnitedHealthcare**

Number	Indicator	Response
	An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the appeal was filed).	0
D1.IV.4	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed an appeal** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter “N/A”. Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter “N/A”. The appeal and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the appeal	**Healthy Blue** 0 **Home State Health Plan** 0 **UnitedHealthcare** 0

Number	Indicator	Response
	need to have been filed in relation to delivery of LTSS — they may have been filed for any reason, related to any service received (or desired) by an LTSS user. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.	
D1.IV.5a	**Standard appeals for which timely resolution was provided** Enter the total number of standard appeals for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	**Healthy Blue** 4,301 **Home State Health Plan** 2,115 **UnitedHealthcare** 3,601
D1.IV.5b	**Expedited appeals for which timely resolution was provided** Enter the total number of expedited appeals for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	**Healthy Blue** 7 **Home State Health Plan** 20 **UnitedHealthcare** 60

Number	Indicator	Response
D1.IV.6a	**Resolved appeals related to denial of authorization or limited authorization of a service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of authorization for a service not yet rendered or limited authorization of a service. (Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	**Healthy Blue** 1,104 **Home State Health Plan** 2,200 **UnitedHealthcare** 455
D1.IV.6b	**Resolved appeals related to reduction, suspension, or termination of a previously authorized service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's reduction, suspension, or termination of a previously authorized service.	**Healthy Blue** 0 **Home State Health Plan** 0 **UnitedHealthcare** 2
D1.IV.6c	**Resolved appeals related to payment denial** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial, in whole or in part, of payment for a service that was already rendered.	**Healthy Blue** 4,160 **Home State Health Plan** 227 **UnitedHealthcare**

Number	Indicator	Response
		3,584
D1.IV.6d	**Resolved appeals related to service timeliness** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to provide services in a timely manner (as defined by the state).	**Healthy Blue** 0 **Home State Health Plan** 0 **UnitedHealthcare** 0
D1.IV.6e	**Resolved appeals related to lack of timely plan response to an appeal or grievance** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to act within the timeframes provided at 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.	**Healthy Blue** 0 **Home State Health Plan** 0 **UnitedHealthcare** 0
D1.IV.6f	**Resolved appeals related to plan denial of an enrollee's right to request out-of-network care** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network	**Healthy Blue** 0 **Home State Health Plan** 0 **UnitedHealthcare** 0

Number	Indicator	Response
	(only applicable to residents of rural areas with only one MCO).	
D1.IV.6g	**Resolved appeals related to denial of an enrollee's request to dispute financial liability** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to dispute a financial liability.	**Healthy Blue** 0 **Home State Health Plan** 0 **UnitedHealthcare** 0

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
D1.IV.7a	**Resolved appeals related to general inpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include appeals related to inpatient behavioral health services – those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter "N/A".	**Healthy Blue** 734 **Home State Health Plan** 172 **UnitedHealthcare** 1,818
D1.IV.7b	**Resolved appeals related to general outpatient services**	**Healthy Blue** 3,207

Number	Indicator	Response
	Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Please do not include appeals related to outpatient behavioral health services – those should be included in indicator D1.IV.7d. If the managed care plan does not cover general outpatient services, enter "N/A".	**Home State Health Plan** 1,326 **UnitedHealthcare** 934
D1.IV.7c	**Resolved appeals related to inpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover inpatient behavioral health services, enter "N/A".	**Healthy Blue** 665 **Home State Health Plan** 83 **UnitedHealthcare** 129
D1.IV.7d	**Resolved appeals related to outpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover outpatient behavioral health services, enter "N/A".	**Healthy Blue** 0 **Home State Health Plan** 4 **UnitedHealthcare** 7

Number	Indicator	Response
D1.IV.7e	**Resolved appeals related to covered outpatient prescription drugs** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover outpatient prescription drugs, enter "N/A".	**Healthy Blue** 0 **Home State Health Plan** 0 **UnitedHealthcare** 0
D1.IV.7f	**Resolved appeals related to skilled nursing facility (SNF) services** Enter the total number of appeals resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover skilled nursing services, enter "N/A".	**Healthy Blue** 0 **Home State Health Plan** 0 **UnitedHealthcare** 0
D1.IV.7g	**Resolved appeals related to long-term services and supports (LTSS)** Enter the total number of appeals resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover LTSS services, enter "N/A".	**Healthy Blue** 0 **Home State Health Plan** 0 **UnitedHealthcare** 0

Number	Indicator	Response
D1.IV.7h	**Resolved appeals related to dental services** Enter the total number of appeals resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover dental services, enter "N/A".	**Healthy Blue** 180 **Home State Health Plan** 200 **UnitedHealthcare** 222
D1.IV.7i	**Resolved appeals related to non-emergency medical transportation (NEMT)** Enter the total number of appeals resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover NEMT, enter "N/A".	**Healthy Blue** 0 **Home State Health Plan** 0 **UnitedHealthcare** 41
D1.IV.7j	**Resolved appeals related to other service types** Enter the total number of appeals resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.7a-i, enter "N/A".	**Healthy Blue** 521 **Home State Health Plan** 618 **UnitedHealthcare** 915

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response

Number	Indicator	Response
D1.IV.8a	**State Fair Hearing requests** Enter the total number of requests for a State Fair Hearing filed during the reporting year by plan that issued the adverse benefit determination.	**Healthy Blue** 12 **Home State Health Plan** 6 **UnitedHealthcare** 12
D1.IV.8b	**State Fair Hearings resulting in a favorable decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.	**Healthy Blue** 2 **Home State Health Plan** 0 **UnitedHealthcare** 0
D1.IV.8c	**State Fair Hearings resulting in an adverse decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee.	**Healthy Blue** 5 **Home State Health Plan** 2 **UnitedHealthcare** 4
D1.IV.8d	**State Fair Hearings retracted prior to reaching a decision** Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the	**Healthy Blue** 4 **Home State Health Plan** 1

Number	Indicator	Response
	representative who filed a State Fair Hearing request on behalf of the enrollee) prior to reaching a decision.	**UnitedHealthcare** 4
D1.IV.9a	**External Medical Reviews resulting in a favorable decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were partially or fully favorable to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**Healthy Blue** N/A **Home State Health Plan** N/A **UnitedHealthcare** N/A
D1.IV.9b	**External Medical Reviews resulting in an adverse decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were adverse to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**Healthy Blue** N/A **Home State Health Plan** N/A **UnitedHealthcare** N/A

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
D1.IV.10	**Grievances resolved** Enter the total number of grievances resolved by the plan during the reporting year. A grievance is "resolved" when it has reached completion and been closed by the plan.	**Healthy Blue** 668 **Home State Health Plan** 319 **UnitedHealthcare** 335
D1.IV.11	**Active grievances** Enter the total number of grievances still pending or in process (not yet resolved) as of the first day of the last month of the reporting year.	**Healthy Blue** 7 **Home State Health Plan** 58 **UnitedHealthcare** 56
D1.IV.12	**Grievances filed on behalf of LTSS users** Enter the total number of grievances filed during the reporting year by or on behalf of LTSS users. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the grievance was filed). If this does not apply, enter N/A.	**Healthy Blue** 0 **Home State Health Plan** 0 **UnitedHealthcare** 0

Number	Indicator	Response
D1.IV.13	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period by (or on behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user. If the managed care plan does not cover LTSS, the state should enter "N/A" in this field. Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter "N/A" in this field.	**Healthy Blue** 0 **Home State Health Plan** 0 **UnitedHealthcare** 0

Number	Indicator	Response
	To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the grievance preceded the filing of the critical incident.	
D1.IV.14	**Number of grievances for which timely resolution was provided** Enter the number of grievances for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	**Healthy Blue** 631 **Home State Health Plan** 256 **UnitedHealthcare** 254

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
D1.IV.15a	**Resolved grievances related to general inpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include grievances related to inpatient behavioral health services — those should be included in	**Healthy Blue** 43 **Home State Health Plan** 12 **UnitedHealthcare** 47

Number	Indicator	Response
	indicator D1.IV.15c. If the managed care plan does not cover this type of service, enter "N/A".	
D1.IV.15b	**Resolved grievances related to general outpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Do not include grievances related to outpatient behavioral health services — those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".	**Healthy Blue** 174 **Home State Health Plan** 24 **UnitedHealthcare** 61
D1.IV.15c	**Resolved grievances related to inpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	**Healthy Blue** 3 **Home State Health Plan** 6 **UnitedHealthcare** 0
D1.IV.15d	**Resolved grievances related to outpatient behavioral health services**	**Healthy Blue** 8

Number	Indicator	Response
	Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	**Home State Health Plan** 2 **UnitedHealthcare** 6
D1.IV.15e	**Resolved grievances related to coverage of outpatient prescription drugs** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter "N/A".	**Healthy Blue** 6 **Home State Health Plan** 1 **UnitedHealthcare** 0
D1.IV.15f	**Resolved grievances related to skilled nursing facility (SNF) services** Enter the total number of grievances resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover this type of service, enter "N/A".	**Healthy Blue** 0 **Home State Health Plan** 0 **UnitedHealthcare** 0
D1.IV.15g	**Resolved grievances related to long-term services and supports (LTSS)** Enter the total number of grievances resolved by the plan	**Healthy Blue** 0 **Home State Health Plan** 0

Number	Indicator	Response
	during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter "N/A".	**UnitedHealthcare** 0
D1.IV.15h	**Resolved grievances related to dental services** Enter the total number of grievances resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover this type of service, enter "N/A".	**Healthy Blue** 48 **Home State Health Plan** 53 **UnitedHealthcare** 40
D1.IV.15i	**Resolved grievances related to non-emergency medical transportation (NEMT)** Enter the total number of grievances resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover this type of service, enter "N/A".	**Healthy Blue** 254 **Home State Health Plan** 178 **UnitedHealthcare** 135
D1.IV.15j	**Resolved grievances related to other service types** Enter the total number of grievances resolved by the plan during the reporting year that were related to services that do not fit into one of the	**Healthy Blue** 126 **Home State Health Plan** 37 **UnitedHealthcare**

Number	Indicator	Response
	categories listed above. If the managed care plan does not cover services other than those in items D1.IV.15a-i, enter "N/A".	35

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
D1.IV.16a	**Resolved grievances related to plan or provider customer service** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service. Customer service grievances include complaints about interactions with the plan's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.	**Healthy Blue** 22 **Home State Health Plan** 39 **UnitedHealthcare** 20
D1.IV.16b	**Resolved grievances related to plan or provider care management/case management** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider care	**Healthy Blue** 0 **Home State Health Plan** 0 **UnitedHealthcare** 0

Number	Indicator	Response
	management/case management. Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.	
D1.IV.16c	**Resolved grievances related to access to care/services from plan or provider** Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.	**Healthy Blue** 20 **Home State Health Plan** 1 **UnitedHealthcare** 54
D1.IV.16d	**Resolved grievances related to quality of care** Enter the total number of grievances resolved by the plan during the reporting year that were related to quality of care. Quality of care grievances include complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the plan.	**Healthy Blue** 32 **Home State Health Plan** 21 **UnitedHealthcare** 32

Number	Indicator	Response
D1.IV.16e	**Resolved grievances related to plan communications** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan communications. Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.	**Healthy Blue** 54 **Home State Health Plan** 8 **UnitedHealthcare** 8
D1.IV.16f	**Resolved grievances related to payment or billing issues** Enter the total number of grievances resolved during the reporting period that were filed for a reason related to payment or billing issues.	**Healthy Blue** 218 **Home State Health Plan** 0 **UnitedHealthcare** 115
D1.IV.16g	**Resolved grievances related to suspected fraud** Enter the total number of grievances resolved during the reporting year that were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetuated by a provider,	**Healthy Blue** 4 **Home State Health Plan** 0 **UnitedHealthcare** 0

Number	Indicator	Response
	payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.	
D1.IV.16h	**Resolved grievances related to abuse, neglect or exploitation** Enter the total number of grievances resolved during the reporting year that were related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.	**Healthy Blue** 0 **Home State Health Plan** 0 **UnitedHealthcare** 0
D1.IV.16i	**Resolved grievances related to lack of timely plan response to a service authorization or appeal (including requests to expedite or extend appeals)** Enter the total number of grievances resolved during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).	**Healthy Blue** 0 **Home State Health Plan** 0 **UnitedHealthcare** 0

Number	Indicator	Response
D1.IV.16j	**Resolved grievances related to plan denial of expedited appeal** Enter the total number of grievances resolved during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal. If a plan denies a request for an expedited appeal, the enrollee or their representative have the right to file a grievance.	**Healthy Blue** 0 **Home State Health Plan** 0 **UnitedHealthcare** 0
D1.IV.16k	**Resolved grievances filed for other reasons** Enter the total number of grievances resolved during the reporting period that were filed for a reason other than the reasons listed above.	**Healthy Blue** 229 **Home State Health Plan** 204 **UnitedHealthcare** 6

Topic VII: Quality & Performance Measures

Report on individual measures in each of the following eight domains: (1) Primary care access and preventive care, (2) Maternal and perinatal health, (3) Care of acute and chronic conditions, (4) Behavioral health care, (5) Dental and oral health services, (6) Health plan enrollee experience of care, (7) Long-term services and supports, and

(8) Other. For composite measures, be sure to include each individual sub-measure component.

Find in the Excel Workbook
D2_Plan_Measures

Complete

D2.VII.1 Measure Name: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) - BMI percentile (Total)

1 / 70

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0024

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"Assesses children and adolescents 3-17 years of age who had an outpatient visit with a primary care practitioner or OB/GYN during the measurement year and had evidence of: Body mass index (BMI) percentile documentation. Counseling for nutrition. Counseling for physical activity. Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed, rather than an absolute BMI value."

Measure results

Healthy Blue

55.47%

Home State Health Plan

80.54%

UnitedHealthcare

74.21%

Complete

D2.VII.1 Measure Name: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) - Counseling for Nutrition (Total)

2 / 70

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0024

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"Assesses children and adolescents 3-17 years of age who had an outpatient visit with a primary care practitioner or OB/GYN during the measurement year and had evidence of: Body mass index (BMI) percentile documentation. Counseling for nutrition. Counseling for physical activity. Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed, rather than an absolute BMI value."

Measure results

Healthy Blue

53.04%

Home State Health Plan

68.86%

UnitedHealthcare

62.53%

Complete

D2.VII.1 Measure Name: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) - Counseling for Physical Activity (Total)

3 / 70

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0024

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"Assesses children and adolescents 3-17 years of age who had an outpatient visit with a primary care practitioner or OB/GYN during the measurement year and had evidence of: Body mass index (BMI) percentile documentation. Counseling for nutrition. Counseling for physical activity. Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed, rather than an absolute BMI value."

Measure results

Healthy Blue

48.18%

Home State Health Plan

60.58%

UnitedHealthcare

55.47%

Complete

D2.VII.1 Measure Name: Childhood Immunization Status (CIS) - DTaP

4 / 70

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0038

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"The percentage of children 2 years of age who had a four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates."

Measure results

Healthy Blue

59.12%

Home State Health Plan

64.72%

UnitedHealthcare

56.69%

Complete

D2.VII.1 Measure Name: Childhood Immunization Status (CIS) - IPV

5 / 70

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0038

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"The percentage of children 2 years of age who had a four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate

(PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates."

Measure results

Healthy Blue

78.59%

Home State Health Plan

81.75%

UnitedHealthcare

75.43%

Complete

D2.VII.1 Measure Name: Childhood Immunization Status (CIS) - MMR

6 / 70

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0038

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"The percentage of children 2 years of age who had a four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates."

Measure results

Healthy Blue

75.18%

Home State Health Plan

77.13%

UnitedHealthcare

74.7%

Complete

D2.VII.1 Measure Name: Childhood Immunization Status (CIS) - HiB

7 / 70

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0038

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"The percentage of children 2 years of age who had a four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates."

Measure results

Healthy Blue

73.24%

Home State Health Plan

77.37%

UnitedHealthcare

70.8%

Complete

D2.VII.1 Measure Name: Childhood Immunization Status (CIS) - Hepatitis B

8 / 70

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0038

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"The percentage of children 2 years of age who had a four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates."

Measure results

Healthy Blue

80.54%

Home State Health Plan

83.21%

UnitedHealthcare

79.32%

Complete

D2.VII.1 Measure Name: Childhood Immunization Status (CIS) - VZV

9 / 70

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0038

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"The percentage of children 2 years of age who had a four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates."

Measure results

Healthy Blue

74.94%

Home State Health Plan

76.16%

UnitedHealthcare

73.72%

Complete

D2.VII.1 Measure Name: Childhood Immunization Status (CIS) - Pneumococcal Conjugate

10 / 70

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0038

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"The percentage of children 2 years of age who had a four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates."

Measure results

Healthy Blue

61.31%

Home State Health Plan

65.69%

UnitedHealthcare

61.8%

Complete

D2.VII.1 Measure Name: Childhood Immunization Status (CIS) - Hepatitis A

11 / 70

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0038

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"The percentage of children 2 years of age who had a four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates."

Measure results

Healthy Blue

67.64%

Home State Health Plan

72.26%

UnitedHealthcare

67.4%

Complete

D2.VII.1 Measure Name: Childhood Immunization Status (CIS) - Rotavirus

12 / 70

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0038

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"The percentage of children 2 years of age who had a four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three

hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates."

Measure results

Healthy Blue

64.96%

Home State Health Plan

66.91%

UnitedHealthcare

62.04%

Complete

D2.VII.1 Measure Name: Childhood Immunization Status (CIS) - Influenza

13 / 70

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0038

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"The percentage of children 2 years of age who had a four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates."

Measure results

Healthy Blue

38.44%

Home State Health Plan

39.42%

UnitedHealthcare

36.5%

Complete

D2.VII.1 Measure Name: Childhood Immunization Status (CIS) - Combo 3

14 / 70

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0038

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"The percentage of children 2 years of age who had a four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates."

Measure results

Healthy Blue

53.53%

Home State Health Plan

58.39%

UnitedHealthcare

54.26%

Complete

D2.VII.1 Measure Name: Childhood Immunization Status (CIS) - Combo 7

15 / 70

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0038

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"The percentage of children 2 years of age who had a four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates."

Measure results

Healthy Blue

45.74%

Home State Health Plan

49.88%

UnitedHealthcare

45.01%

Complete

D2.VII.1 Measure Name: Childhood Immunization Status (CIS) - Combo 10

16 / 70

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0038

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"The percentage of children 2 years of age who had a four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates."

Measure results

Healthy Blue

26.28%

Home State Health Plan

30.41%

UnitedHealthcare

25.3%

Complete

D2.VII.1 Measure Name: Immunizations for Adolescents (IMA) - Meningococcal

17 / 70

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

1407

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Assesses adolescents 13 years of age who had one dose of meningococcal vaccine, one Tdap vaccine and the complete human papillomavirus vaccine series by their 13th birthday.

Measure results

Healthy Blue

55.96%

Home State Health Plan

58.64%

UnitedHealthcare

48.18%

Complete

D2.VII.1 Measure Name: Immunizations for Adolescents (IMA) - Tdap

18 / 70

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

1407

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Assesses adolescents 13 years of age who had one dose of meningococcal vaccine, one Tdap vaccine and the complete human papillomavirus vaccine series by their 13th birthday.

Measure results

Healthy Blue

56.93%

Home State Health Plan

60.58%

UnitedHealthcare

0.50

Complete

D2.VII.1 Measure Name: Immunizations for Adolescents (IMA) - HPV

19 / 70

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

1407

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Assesses adolescents 13 years of age who had one dose of meningococcal vaccine, one Tdap vaccine and the complete human papillomavirus vaccine series by their 13th birthday.

Measure results

Healthy Blue

24.33%

Home State Health Plan

21.65%

UnitedHealthcare

21.9%

Complete

D2.VII.1 Measure Name: Immunizations for Adolescents (IMA) - Combination 1

20 / 70

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

1407

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Assesses adolescents 13 years of age who had one dose of meningococcal vaccine, one Tdap vaccine and the complete human papillomavirus vaccine series by their 13th birthday.

Measure results

Healthy Blue

55.23%

Home State Health Plan

58.64%

UnitedHealthcare

47.45%

Complete

D2.VII.1 Measure Name: Immunizations for Adolescents (IMA) - Combination 2

21 / 70

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

1407

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Assesses adolescents 13 years of age who had one dose of meningococcal vaccine, one Tdap vaccine and the complete human papillomavirus vaccine series by their 13th birthday.

Measure results

Healthy Blue

23.36%

Home State Health Plan

21.17%

UnitedHealthcare

21.17%

Complete

D2.VII.1 Measure Name: Breast Cancer Screening (BCS)

22 / 70

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

2372

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

This HEDIS measure assesses women 50–74 years of age who had at least one mammogram to screen for breast cancer in the past two years.

Measure results

Healthy Blue

41.4%

Home State Health Plan

39.22%

UnitedHealthcare

41.44%

Complete

D2.VII.1 Measure Name: Cervical Cancer Screening (CCS)

23 / 70

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0032

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"Assesses women who were screened for cervical cancer using any of the following criteria: Women 21–64 years of age who had cervical cytology performed within the last 3 years. Women 30–64 years of age who had

cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years. Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years"

Measure results

Healthy Blue

59.64%

Home State Health Plan

61.73%

UnitedHealthcare

56.69%

Complete

D2.VII.1 Measure Name: Chlamydia Screening in Women (CHL) - Total

24 / 70

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0033

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Measure results

Healthy Blue

47.63%

Home State Health Plan

44.55%

UnitedHealthcare

50.16%

Complete

D2.VII.1 Measure Name: Lead Screening in Children (LSC)

25 / 70

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

Measure results

Healthy Blue

0.56

Home State Health Plan

57.91%

UnitedHealthcare

53.28%

Complete

D2.VII.1 Measure Name: Asthma Medication Ratio (AMR) - Total

26 / 70

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

1800

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Assesses adults and children 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Measure results

Healthy Blue

56.11%

Home State Health Plan

63.15%

UnitedHealthcare

56%

Complete

D2.VII.1 Measure Name: Controlling High Blood Pressure (CBP)

27 / 70

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

0018

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Assesses adults 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg).

Measure results

Healthy Blue

46.34%

Home State Health Plan

61.56%

UnitedHealthcare

58.15%

Complete

D2.VII.1 Measure Name: Comprehensive Diabetes Care (CDC) - HbA1c Testing

28 / 70

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"Assesses adults 18–75 years of age with diabetes (type 1 and type 2) who had each of the following: Hemoglobin A1c (HbA1c) testing. HbA1c poor control (>9.0%). HbA1c control (<8.0%). Eye exam (retinal) performed. Medical attention for nephropathy.* BP control (<140/90 mm Hg). *This indicator is only reported for the Medicare product line."

Measure results

Healthy Blue

78.35%

Home State Health Plan

81.75%

UnitedHealthcare

82.73%

Complete

D2.VII.1 Measure Name: Comprehensive Diabetes Care (CDC) - Poor HbA1c Control

29 / 70

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

0059

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"Assesses adults 18–75 years of age with diabetes (type 1 and type 2) who had each of the following: Hemoglobin A1c (HbA1c) testing. HbA1c poor control (>9.0%). HbA1c control (<8.0%). Eye exam (retinal) performed. Medical attention for nephropathy.* BP control (<140/90 mm Hg). *This indicator is only reported for the Medicare product line."

Measure results

Healthy Blue

56.2%

Home State Health Plan

45.99%

UnitedHealthcare

48.66%

Complete

D2.VII.1 Measure Name: Comprehensive Diabetes Care (CDC) - HbA1c Control (<8%)

30 / 70

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

0575

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"Assesses adults 18–75 years of age with diabetes (type 1 and type 2) who had each of the following: Hemoglobin A1c (HbA1c) testing. HbA1c poor control (>9.0%). HbA1c control (<8.0%). Eye exam (retinal) performed. Medical attention for nephropathy.* BP control (<140/90 mm Hg). *This indicator is only reported for the Medicare product line."

Measure results

Healthy Blue

36.01%

Home State Health Plan

44.53%

UnitedHealthcare

42.34%

Complete

D2.VII.1 Measure Name: Comprehensive Diabetes Care (CDC) - Eye Exams

31 / 70

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

0055

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"Assesses adults 18–75 years of age with diabetes (type 1 and type 2) who had each of the following: Hemoglobin A1c (HbA1c) testing. HbA1c poor control (>9.0%). HbA1c control (<8.0%). Eye exam (retinal) performed. Medical attention for nephropathy.* BP control (<140/90 mm Hg). *This indicator is only reported for the Medicare product line."

Measure results

Healthy Blue

42.09%

Home State Health Plan

43.31%

UnitedHealthcare

43.55%

Complete

D2.VII.1 Measure Name: Comprehensive Diabetes Care (CDC) - Blood Pressure Control (<140/90)

32 / 70

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

D2.VII.4 Measure Reporting and D2.VII.5 Programs

0061

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"Assesses adults 18–75 years of age with diabetes (type 1 and type 2) who had each of the following: Hemoglobin A1c (HbA1c) testing. HbA1c poor control (>9.0%). HbA1c control (<8.0%). Eye exam (retinal) performed. Medical attention for nephropathy.* BP control (<140/90 mm Hg). *This indicator is only reported for the Medicare product line."

Measure results

Healthy Blue

57.18%

Home State Health Plan

68.61%

UnitedHealthcare

64.96%

Complete

D2.VII.1 Measure Name: Antidepressant Medication Management (AMM) - Effective Acute Phase Treatment

33 / 70

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

0105

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"Assesses adults 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication and

remained on their antidepressant medications. Two rates are reported: Effective Acute Phase Treatment: Adults who remained on an antidepressant medication for at least 84 days (12 weeks). Effective Continuation Phase Treatment: Adults who remained on an antidepressant medication for at least 180 days (6 months)."

Measure results

Healthy Blue

62.76%

Home State Health Plan

49.32%

UnitedHealthcare

59.49%

Complete

D2.VII.1 Measure Name: Antidepressant Medication Management (AMM) - Effective Continuation Phase Treatment

34 / 70

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

0105

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"Assesses adults 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication and remained on their antidepressant medications. Two rates are reported: Effective Acute Phase Treatment: Adults who remained on an antidepressant medication for at least 84 days (12 weeks). Effective Continuation Phase Treatment: Adults who remained on an antidepressant medication for at least 180 days (6 months)."

Measure results

Healthy Blue

43.11%

Home State Health Plan

30.47%

UnitedHealthcare

43.43%

Complete

D2.VII.1 Measure Name: Follow-Up Care for Children Prescribed ADHD Medication (ADD) - Initiation Phase

35 / 70

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

0108

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"The two rates of this measure assess follow-up care for children prescribed an ADHD medication: Initiation Phase: Assesses children between 6 and 12 years of age who were diagnosed with ADHD and had one follow-up visit with a practitioner with prescribing authority within 30 days of their first prescription of ADHD medication. Continuation and Maintenance Phase: Assesses children between 6 and 12 years of age who had a prescription for ADHD medication and remained on the medication for at least 210 days, and had at least two follow-up visits with a practitioner in the 9 months after the Initiation Phase."

Measure results

Healthy Blue

33.3%

Home State Health Plan

36.02%

UnitedHealthcare

41.96%

Complete

D2.VII.1 Measure Name: Follow-Up Care for Children Prescribed ADHD Medication (ADD) - Continuation and Maintenance Phase

36 / 70

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

0108

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"The two rates of this measure assess follow-up care for children prescribed an ADHD medication: Initiation Phase: Assesses children between 6 and 12 years of age who were diagnosed with ADHD and had one follow-up visit with a practitioner with prescribing authority within 30 days of their first prescription of ADHD medication. Continuation and Maintenance Phase: Assesses children between 6 and 12 years of age who had a prescription for ADHD medication and remained on the medication for at least 210 days, and had at least two follow-up visits with a practitioner in the 9 months after the Initiation Phase."

Measure results

Healthy Blue

43.52%

Home State Health Plan

44.67%

UnitedHealthcare

52.9%

Complete

D2.VII.1 Measure Name: Follow-up After Hospitalization for Mental Illness (FUH) - 30 days (Total)

37 / 70

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

0576

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Assesses the percentage of inpatient discharges for a diagnosis of mental illness or intentional self-harm among patients age 6 years and older that resulted in follow-up care with a mental health provider within 7 and 30 days.

Measure results

Healthy Blue

41.46%

Home State Health Plan

57.79%

UnitedHealthcare

51.19%

Complete

D2.VII.1 Measure Name: Follow-up After Hospitalization for Mental Illness (FUH) - 7 days (Total)

38 / 70

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

0576

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Assesses the percentage of inpatient discharges for a diagnosis of mental illness or intentional self-harm among patients age 6 years and older that resulted in follow-up care with a mental health provider within 7 and 30 days.

Measure results

Healthy Blue

23.16%

Home State Health Plan

36.31%

UnitedHealthcare

27.67%

Complete

D2.VII.1 Measure Name: Follow-up After Emergency Department Visit for Mental Illness (FUM) - 30 days (Total)

39 / 70

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

3489

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Assesses emergency department (ED) visits for adults and children 6 years of age and older with a diagnosis of mental illness or intentional self-harm and who received a follow-up visit for mental illness within 7 and 30 days.

Measure results

Healthy Blue

50%

Home State Health Plan

51.39%

UnitedHealthcare

47.19%

Complete

D2.VII.1 Measure Name: Follow-up After Emergency Department Visit for Mental Illness (FUM) - 7 days (Total) 40 / 70

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

3489

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Assesses emergency department (ED) visits for adults and children 6 years of age and older with a diagnosis of mental illness or intentional self-harm and who received a follow-up visit for mental illness within 7 and 30 days.

Measure results

Healthy Blue

32.56%

Home State Health Plan

34.55%

UnitedHealthcare

33.71%

Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) - 30 days (Total)

41 / 70

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

3488

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"Assesses emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. Two rates are reported: ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). ED visits for which the member received follow-up within 7 days of the ED visit (8 total days)."

Measure results

Healthy Blue

15.23%

Home State Health Plan

17%

UnitedHealthcare

16.39%

Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) - 7 days (Total) 42 / 70

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

3488

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"Assesses emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. Two rates are reported: ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). ED visits for which the member received follow-up within 7 days of the ED visit (8 total days)."

Measure results

Healthy Blue

9.48%

Home State Health Plan

12.12%

UnitedHealthcare

11.36%

Complete

D2.VII.1 Measure Name: Pharmacotherapy for Opioid Use Disorder (POD) - Total

43 / 70

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Assesses the percentage of opioid use disorder (OUD) pharmacotherapy treatment events among members age 16 and older that continue for at least 180 days (6 months).

Measure results

Healthy Blue

28.94%

Home State Health Plan

10.38%

UnitedHealthcare

24.41%

Complete

D2.VII.1 Measure Name: Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)

44 / 70

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Assesses adults 18 years of age and older who have schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.

Measure results

Healthy Blue

40.35%

Home State Health Plan

30.38%

UnitedHealthcare

50.82%

Complete

D2.VII.1 Measure Name: Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) - Blood Glucose Testing (Total)

45 / 70

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

2800

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Assesses the percentage of children and adolescents with ongoing antipsychotic medication use who had metabolic testing during the year.

Measure results

Healthy Blue

58.69%

Home State Health Plan

62.65%

UnitedHealthcare

64.17%

Complete

D2.VII.1 Measure Name: Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) - Cholesterol Testing (Total)

46 / 70

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

2800

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Assesses the percentage of children and adolescents with ongoing antipsychotic medication use who had metabolic testing during the year.

Measure results

Healthy Blue

40.86%

Home State Health Plan

45.35%

UnitedHealthcare

46.41%

Complete

D2.VII.1 Measure Name: Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) - Blood Glucose and Cholesterol Testing (Total)

47 / 70

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

2800

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Assesses the percentage of children and adolescents with ongoing antipsychotic medication use who had metabolic testing during the year.

Measure results

Healthy Blue

38.88%

Home State Health Plan

43.74%

UnitedHealthcare

45.62%

Complete

D2.VII.1 Measure Name: Use of Opioids at High Dosage (HDO)

48 / 70

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Assesses potentially high-risk opioid analgesic prescribing practices: The proportion of members 18 years and older who received prescription opioids at a high dosage (average morphine milligram equivalent dose [MME] ≥90) for ≥15 days during the measurement year.

Measure results

Healthy Blue

3%

Home State Health Plan

0%

UnitedHealthcare

1.48%

Complete

D2.VII.1 Measure Name: Use of Opioids From Multiple Providers (UOP) Multiple Prescribers

49 / 70

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"Assesses potentially high-risk opioid analgesic prescribing practices: The proportion of members 18 years and older, receiving prescription opioids for ≥15 days during the measurement year from multiple providers. Three rates are reported. Multiple Prescribers: The proportion of members receiving prescriptions for opioids from four or more different prescribers during the measurement year. Multiple Pharmacies: The proportion of members receiving prescriptions for opioids from four or more different pharmacies during the measurement year. Multiple Prescribers and Multiple Pharmacies: The proportion of members receiving prescriptions for opioids from four or more different prescribers and four or more different pharmacies during the measurement year (i.e., the proportion of members who are numerator compliant for both the Multiple Prescribers and Multiple Pharmacies rates)."

Measure results

Healthy Blue

15.44%

Home State Health Plan

81.69%

UnitedHealthcare

20.85%

Complete

D2.VII.1 Measure Name: Use of Opioids From Multiple Providers (UOP) Multiple Pharmacies

50 / 70

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"Assesses potentially high-risk opioid analgesic prescribing practices: The proportion of members 18 years and older, receiving prescription opioids for ≥15 days during the measurement year from multiple providers. Three rates are reported. Multiple Prescribers: The proportion of members receiving prescriptions for opioids from four or more different prescribers during the measurement year. Multiple Pharmacies: The proportion of members receiving prescriptions for opioids from four or more different pharmacies during the measurement year. Multiple Prescribers and Multiple Pharmacies: The proportion of members receiving prescriptions for opioids from four or more different prescribers and four or more different pharmacies during the measurement year (i.e., the proportion of members who are numerator compliant for both the Multiple Prescribers and Multiple Pharmacies rates)."

Measure results

Healthy Blue

8.18%

Home State Health Plan

5.89%

UnitedHealthcare

8.73%

Complete

D2.VII.1 Measure Name: Use of Opioids From Multiple Providers (UOP) Multiple Prescribers and Multiple Pharmacies

51 / 70

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"Assesses potentially high-risk opioid analgesic prescribing practices: The proportion of members 18 years and older, receiving prescription opioids for ≥15 days during the measurement year from multiple providers. Three rates are reported. Multiple Prescribers: The proportion of members receiving prescriptions for opioids from four or more different prescribers during the measurement year. Multiple Pharmacies: The proportion of members receiving prescriptions for opioids from four or more different pharmacies during the measurement year. Multiple Prescribers and Multiple Pharmacies: The proportion of members receiving prescriptions for opioids from four or more different prescribers and four or more different pharmacies during the measurement year (i.e., the proportion of members who are numerator compliant for both the Multiple Prescribers and Multiple Pharmacies rates)."

Measure results

Healthy Blue

4.86%

Home State Health Plan

5.84%

UnitedHealthcare

6.43%

Complete

D2.VII.1 Measure Name: Annual Dental Visit (ADV) - Total

52 / 70

D2.VII.2 Measure Domain

Dental and oral health services

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Assesses Medicaid members 2 – 20 years of age with dental benefits, who had at least one dental visit during the year.

Measure results

Healthy Blue

42.31%

Home State Health Plan

44.93%

UnitedHealthcare

42.39%

Complete

D2.VII.1 Measure Name: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) - Initiation of AOD - Alcohol Abuse or Dependence (Total)

53 / 70

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

0004

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"Assesses adults and adolescents 13 years of age and older with a new episode of alcohol or other drug (AOD) dependence who received the following: Initiation of AOD Treatment: Adolescents and adults who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication-

assisted treatment (MAT) within 14 days of diagnosis. Engagement of AOD Treatment: Adolescents and adults who initiated treatment and had two or more additional AOD services or MAT within 34 days of the initiation visit."

Measure results

Healthy Blue

45.58%

Home State Health Plan

47.96%

UnitedHealthcare

41.87%

Complete

D2.VII.1 Measure Name: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) - Engagement of AOD - Alcohol Abuse or Dependence (Total) 54 / 70

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

0004

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"Assesses adults and adolescents 13 years of age and older with a new episode of alcohol or other drug (AOD) dependence who received the following: Initiation of AOD Treatment: Adolescents and adults who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication-assisted treatment (MAT) within 14 days of diagnosis. Engagement of AOD Treatment: Adolescents and adults who initiated treatment and had two or more additional AOD services or MAT within 34 days of the initiation visit."

Measure results

Healthy Blue

10%

Home State Health Plan

11.09%

UnitedHealthcare

9.37%

Complete

D2.VII.1 Measure Name: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) - Initiation of AOD - Opioid Abuse or Dependence (Total)

55 / 70

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

0004

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) - Initiation of AOD - Opioid Abuse or Dependence (Total)

Measure results

Healthy Blue

55.68%

Home State Health Plan

62.5%

UnitedHealthcare

56.88%

Complete

D2.VII.1 Measure Name: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) - Engagement of AOD - Opioid Abuse or Dependence (Total)

56 / 70

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

0004

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"Assesses adults and adolescents 13 years of age and older with a new episode of alcohol or other drug (AOD) dependence who received the following: Initiation of AOD Treatment: Adolescents and adults who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication-assisted treatment (MAT) within 14 days of diagnosis. Engagement of AOD Treatment: Adolescents and adults who initiated treatment and had two or more additional AOD services or MAT within 34 days of the initiation visit."

Measure results

Healthy Blue

24.89%

Home State Health Plan

27.22%

UnitedHealthcare

27.22%

Complete

D2.VII.1 Measure Name: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) - Initiation of AOD - Other Drug Abuse or Dependence (Total)

57 / 70

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

0004

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"Assesses adults and adolescents 13 years of age and older with a new episode of alcohol or other drug (AOD) dependence who received the following: Initiation of AOD Treatment: Adolescents and adults who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication-assisted treatment (MAT) within 14 days of diagnosis. Engagement of AOD Treatment: Adolescents and adults who initiated treatment and had two or more additional AOD services or MAT within 34 days of the initiation visit."

Measure results

Healthy Blue

45.61%

Home State Health Plan

44.9%

UnitedHealthcare

42.35%

Complete

D2.VII.1 Measure Name: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) - Engagement of AOD - Other Drug Abuse or Dependence (Total)

58 / 70

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

0004

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"Assesses adults and adolescents 13 years of age and older with a new episode of alcohol or other drug (AOD) dependence who received the following: Initiation of AOD Treatment: Adolescents and adults who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication-assisted treatment (MAT) within 14 days of diagnosis. Engagement of AOD Treatment: Adolescents and adults who initiated treatment and had two or more additional AOD services or MAT within 34 days of the initiation visit."

Measure results

Healthy Blue

10.61%

Home State Health Plan

8.36%

UnitedHealthcare

8.19%

Complete

D2.VII.1 Measure Name: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) - Initiation of AOD - Total (Total)

59 / 70

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

0004

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"Assesses adults and adolescents 13 years of age and older with a new episode of alcohol or other drug (AOD) dependence who received the following: Initiation of AOD Treatment: Adolescents and adults who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication-assisted treatment (MAT) within 14 days of diagnosis. Engagement of AOD Treatment: Adolescents and adults who initiated treatment and had two or more additional AOD services or MAT within 34 days of the initiation visit."

Measure results

Healthy Blue

46.09%

Home State Health Plan

46.76%

UnitedHealthcare

42.85%

Complete

D2.VII.1 Measure Name: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) - Engagement of AOD - Total (Total)

60 / 70

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

0004

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"Assesses adults and adolescents 13 years of age and older with a new episode of alcohol or other drug (AOD) dependence who received the following: Initiation of AOD Treatment: Adolescents and adults who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication-assisted treatment (MAT) within 14 days of diagnosis. Engagement of AOD Treatment: Adolescents and adults who initiated treatment and had two or more additional AOD services or MAT within 34 days of the initiation visit."

Measure results

Healthy Blue

12.25%

Home State Health Plan

11.52%

UnitedHealthcare

10.85%

Complete

D2.VII.1 Measure Name: Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care

61 / 70

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"Assesses access to prenatal and postpartum care: Timeliness of Prenatal Care. The percentage of deliveries in which women had a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. Postpartum Care. The percentage of

deliveries in which women had a postpartum visit on or between 7 and 84 days after delivery."

Measure results

Healthy Blue

84.66%

Home State Health Plan

91.89%

UnitedHealthcare

90.02%

Complete

D2.VII.1 Measure Name: Prenatal and Postpartum Care (PPC) - Postpartum Care

62 / 70

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"Assesses access to prenatal and postpartum care: Timeliness of Prenatal Care. The percentage of deliveries in which women had a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. Postpartum Care. The percentage of deliveries in which women had a postpartum visit on or between 7 and 84 days after delivery."

Measure results

Healthy Blue

75.72%

Home State Health Plan

81.76%

UnitedHealthcare

74.7%

Complete

D2.VII.1 Measure Name: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) - Total

63 / 70

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

2801

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Assesses the percentage of children and adolescents newly started on antipsychotic medications without a clinical indication who had documentation of psychosocial care as first-line treatment.

Measure results

Healthy Blue

53.22%

Home State Health Plan

54.91%

UnitedHealthcare

53.02%

Complete

D2.VII.1 Measure Name: Well-Child Visits in the First 30 Months of Life (W30) - First 15 Months

64 / 70

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"Well-Child Visits in the First 30 Months of Life: Assesses children who turned 15 months old during the measurement year and had at least six well-child visits with a primary care physician during their first 15 months of life. Assesses children who turned 30 months old during the measurement year and had at least two well-child visits with a primary care physician in the last 15 months. Child and Adolescent Well-Care Visits: Assesses children 3–21years of age who received one or more well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year."

Measure results

Healthy Blue

48.94%

Home State Health Plan

50%

UnitedHealthcare

51.5%

Complete

D2.VII.1 Measure Name: Well-Child Visits in the First 30 Months of Life (W30) - 15 Months-30 Months

65 / 70

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"Well-Child Visits in the First 30 Months of Life: Assesses children who turned 15 months old during the measurement year and had at least six well-child visits with a primary care physician during their first 15 months of life. Assesses children who turned 30 months old during the measurement year and had at least two well-child visits with a primary care physician in the last 15 months. Child and Adolescent Well-Care Visits: Assesses children 3–21years of age who received one or more well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year."

Measure results

Healthy Blue

56.35%

Home State Health Plan

61.19%

UnitedHealthcare

59.29%

Complete

D2.VII.1 Measure Name: Child and Adolescent Well-Care Visits (WCV) - Total

66 / 70

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"Well-Child Visits in the First 30 Months of Life: Assesses children who turned 15 months old during the measurement year and had at least six well-child visits with a primary care physician during their first 15 months of life. Assesses children who turned 30 months old during the measurement year and had at least two well-child visits with a primary care physician in the last 15 months. Child and Adolescent Well-Care Visits: Assesses children 3–21years of age who received one or more well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year."

Measure results

Healthy Blue

42.78%

Home State Health Plan

42.81%

UnitedHealthcare

41.95%

Complete

D2.VII.1 Measure Name: Plan All-Cause Readmissions (PCR) - Total (O/E Ratio) 67 / 70

D2.VII.2 Measure Domain

Other: Inpatient and Emergency Department utilization

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Assesses the rate of adult acute inpatient and observation stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge among commercial (18 to 64), Medicaid (18 to 64) and Medicare (18 and older) health plan members. As well as reporting observed rates, NCQA also specifies that plans report a predicted probability of readmission to account for the prior and current health of the member, among other factors. A separate readmission rate for hospital stays discharged to a skilled nursing facility among members aged 65 and older is reported for Medicare plans. The observed rate and predicted probability is used to calculate a calibrated observed-to-expected ratio that assesses whether plans had more, the same or less readmissions than expected, while accounting for incremental improvements across all plans over time. The observed-to-expected ratio is multiplied by the readmission rate across all health plans to produce a risk-standardized rate which allows for national comparison.

Measure results

Healthy Blue

0.8556

Home State Health Plan

1.1492

UnitedHealthcare

1.1364

Complete

D2.VII.1 Measure Name: Percentage of Primary Care Provider offices that met the urgent appointment standard (24 hours for illness or injury requiring immediate care). 68 / 70

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

State-specific

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Rates calculated based on a "Secret Shopper" Survey conducted annually by our EQRO.

Measure results

Healthy Blue

87.36%

Home State Health Plan

64.55%

UnitedHealthcare

83.72%

Complete

D2.VII.1 Measure Name: Percentage of Primary Care Provider offices that met the routine appointment standard (30 days for routine care without symptoms. 69 / 70

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

State-specific

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Rates calculated based on a "Secret Shopper" Survey conducted annually by our EQRO.

Measure results

Healthy Blue

94.42%

Home State Health Plan

90.45%

UnitedHealthcare

86.05%

Complete

D2.VII.1 Measure Name: Percentage of psychiatrist offices that met the two-week appointment standard for routine behavioral health and substance use services without symptoms.

70 / 70

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

State-specific

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Rates calculated based on a "Secret Shopper" Survey conducted annually by our EQRO.

Measure results

Healthy Blue

42.94%

Home State Health Plan

20%

UnitedHealthcare

47.76%

Topic VIII. Sanctions

Describe sanctions that the state has issued for each plan. Report all known actions across the following domains: sanctions, administrative penalties, corrective action plans, other. Include any pending or unresolved actions.

42 CFR 438.66(e)(2)(viii) specifies that the MCPAR include the results of any sanctions or corrective action plans imposed by the State or other formal or informal intervention with a contracted MCO, PIHP, PAHP, or PCCM entity to improve performance.

Find in the Excel Workbook
D3_Plan_Sanctions

Complete

D3.VIII.1 Intervention type: Corrective action plan

1 / 25

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Healthy Blue

D3.VIII.4 Reason for intervention

Assurance of Adequate Capacity

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

09/19/2022

D3.VIII.8 Remediation date non-compliance was corrected

12/18/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

2 / 25

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Healthy Blue

D3.VIII.4 Reason for intervention

Availability of Services

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

09/19/2022

D3.VIII.8 Remediation date non-compliance was corrected

12/18/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

3 / 25

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Healthy Blue

D3.VIII.4 Reason for intervention

Confidentiality

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

D3.VIII.8 Remediation date non-compliance was corrected

09/19/2022 12/18/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

4 / 25

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Healthy Blue

D3.VIII.4 Reason for intervention

Coordination and Continuity of Care

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

09/19/2022

D3.VIII.8 Remediation date non-compliance was corrected

12/18/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

5 / 25

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Healthy Blue

D3.VIII.4 Reason for intervention

Coverage and Authorization

Sanction details

D3.VIII.5 Instances of non-compliance

D3.VIII.6 Sanction amount

$ 0

1

D3.VIII.7 Date assessed

09/19/2022

D3.VIII.8 Remediation date non-compliance was corrected

12/18/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

6 / 25

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Healthy Blue

D3.VIII.4 Reason for intervention

Provider Selection

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

09/19/2022

D3.VIII.8 Remediation date non-compliance was corrected

12/18/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

7 / 25

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Home State Health Plan

D3.VIII.4 Reason for intervention

Availability of Services

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

09/19/2022

D3.VIII.8 Remediation date non-compliance was corrected

12/18/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

8 / 25

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Home State Health Plan

D3.VIII.4 Reason for intervention

Assurance of Adequate Capacity

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

09/19/2022

D3.VIII.8 Remediation date non-compliance was corrected

12/18/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

9 / 25

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Home State Health Plan

D3.VIII.4 Reason for intervention

Coordination and Continuity of Care

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
$ 0

D3.VIII.7 Date assessed
09/19/2022

D3.VIII.8 Remediation date non-compliance was corrected
12/18/2022

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: Corrective action plan

10 / 25

D3.VIII.2 Intervention topic
Reporting

D3.VIII.3 Plan name
Home State Health Plan

D3.VIII.4 Reason for intervention

Coverage and Authorization

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
$ 0

D3.VIII.7 Date assessed
09/19/2022

D3.VIII.8 Remediation date non-compliance was corrected
12/18/2022

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: Corrective action plan

11 / 25

D3.VIII.2 Intervention topic

D3.VIII.3 Plan name

Reporting Home State Health Plan

D3.VIII.4 Reason for intervention

Provider Selection

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

09/19/2022

D3.VIII.8 Remediation date non-compliance was corrected

12/18/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

12 / 25

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Home State Health Plan

D3.VIII.4 Reason for intervention

Confidentiality

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

09/19/2022

D3.VIII.8 Remediation date non-compliance was corrected

12/18/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

13 / 25

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Home State Health Plan

D3.VIII.4 Reason for intervention

Grievance and Appeal System

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

09/19/2022

D3.VIII.8 Remediation date non-compliance was corrected

12/18/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

14 / 25

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Home State Health Plan

D3.VIII.4 Reason for intervention

Disenrollment

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

09/19/2022

D3.VIII.8 Remediation date non-compliance was corrected

12/18/2022

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

15 / 25

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Home State Health Plan

D3.VIII.4 Reason for intervention

Enrollee Rights

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

09/19/2022

D3.VIII.8 Remediation date non-compliance was corrected

12/18/2022

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

16 / 25

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

UnitedHealthcare

D3.VIII.4 Reason for intervention

Assurance of Adequate Capacity

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

D3.VIII.8 Remediation date non-compliance was corrected

09/19/2022 12/18/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

17 / 25

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

UnitedHealthcare

D3.VIII.4 Reason for intervention

Coordination and Continuity of Care

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

09/19/2022

D3.VIII.8 Remediation date non-compliance was corrected

12/18/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

18 / 25

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

UnitedHealthcare

D3.VIII.4 Reason for intervention

Coverage and Authorization

Sanction details

D3.VIII.5 Instances of non-compliance

D3.VIII.6 Sanction amount

$ 0

1

D3.VIII.7 Date assessed

09/19/2022

D3.VIII.8 Remediation date non-compliance was corrected

12/18/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

19 / 25

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

UnitedHealthcare

D3.VIII.4 Reason for intervention

Provider Selection

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

09/19/2022

D3.VIII.8 Remediation date non-compliance was corrected

12/18/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

20 / 25

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

UnitedHealthcare

D3.VIII.4 Reason for intervention

Confidentiality

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

09/19/2022

D3.VIII.8 Remediation date non-compliance was corrected

12/18/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

21 / 25

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

UnitedHealthcare

D3.VIII.4 Reason for intervention

Grievance and Appeal System

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

09/19/2022

D3.VIII.8 Remediation date non-compliance was corrected

12/18/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

22 / 25

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

UnitedHealthcare

D3.VIII.4 Reason for intervention

Disenrollment

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
$ 0

D3.VIII.7 Date assessed
09/19/2022

D3.VIII.8 Remediation date non-compliance was corrected
12/18/2022

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: Liquidated damages

23 / 25

D3.VIII.2 Intervention topic
Reporting

D3.VIII.3 Plan name
UnitedHealthcare

D3.VIII.4 Reason for intervention
Enrollee Rights

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
$ 0

D3.VIII.7 Date assessed
09/19/2022

D3.VIII.8 Remediation date non-compliance was corrected
12/18/2022

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

24 / 25

D3.VIII.2 Intervention topic

D3.VIII.3 Plan name

Reporting UnitedHealthcare

D3.VIII.4 Reason for intervention

Emergency and Post-stabilization Services

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

09/19/2022

D3.VIII.8 Remediation date non-compliance was corrected

12/18/2022

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

25 / 25

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

UnitedHealthcare

D3.VIII.4 Reason for intervention

Health Information Systems

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

09/19/2022

D3.VIII.8 Remediation date non-compliance was corrected

12/18/2022

D3.VIII.9 Corrective action plan

Yes

Topic X. Program Integrity

Number	Indicator	Response
D1.X.1	**Dedicated program integrity staff** Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii).	**Healthy Blue** 10 **Home State Health Plan** 3 **UnitedHealthcare** 3
D1.X.2	**Count of opened program integrity investigations** How many program integrity investigations have been opened by the plan in the past year?	**Healthy Blue** 158 **Home State Health Plan** 26 **UnitedHealthcare** 376
D1.X.3	**Ratio of opened program integrity investigations to enrollees** What is the ratio of program integrity investigations opened by the plan in the past year per 1,000 beneficiaries enrolled in the plan on the first day of the last month of the reporting year?	**Healthy Blue** 0.42:1,000 **Home State Health Plan** 0.07:1,000 **UnitedHealthcare** 0.99:1,000
D1.X.4	**Count of resolved program integrity investigations** How many program integrity investigations have been	**Healthy Blue** 32 **Home State Health Plan** 13

Number	Indicator	Response
	resolved by the plan in the past year?	**UnitedHealthcare** 217
D1.X.5	**Ratio of resolved program integrity investigations to enrollees** What is the ratio of program integrity investigations resolved by the plan in the past year per 1,000 beneficiaries enrolled in the plan at the beginning of the reporting year?	**Healthy Blue** 0.08:1,000 **Home State Health Plan** 0.03:1,000 **UnitedHealthcare** 0.57:1,000
D1.X.6	**Referral path for program integrity referrals to the state** What is the referral path that the plan uses to make program integrity referrals to the state? Select one.	**Healthy Blue** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **Count of program integrity referrals to the state** 29 **Home State Health Plan** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **Count of program integrity referrals to the state** 26 **UnitedHealthcare** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **Count of program integrity referrals to the state** 54

Number	Indicator	Response
D1.X.8	**Ratio of program integrity referral to the state** What is the ratio of program integrity referral listed in the previous indicator made to the state in the past year per 1,000 beneficiaries, using the plan's total enrollment as of the first day of the last month of the reporting year (reported in indicator D1.I.2) as the denominator.	**Healthy Blue** 0.08 **Home State Health Plan** 0.07 **UnitedHealthcare** 0.14
D1.X.9	**Plan overpayment reporting to the state** Describe the plan's latest annual overpayment recovery report submitted to the state as required under 42 CFR 438.608(d)(3). Include, for example, the following information: • The date of the report (rating period or calendar year). • The dollar amount of overpayments recovered. • The ratio of the dollar amount of overpayments recovered as a percent of premium revenue as defined in MLR reporting under 438.8(f)(2).	**Healthy Blue** 07/01/2021 - 06/30/2022 $106,634.63 0.01% **Home State Health Plan** 07/01/2021-06/30/2022 $1,820,824.75 0.18% **UnitedHealthcare** 07/01/2021-06/30/2022 $45,824.83 0.01%
D1.X.10	**Changes in beneficiary circumstances** Select the frequency the plan reports changes in beneficiary circumstances to the state.	**Healthy Blue** Daily **Home State Health Plan** Daily **UnitedHealthcare**

Number	Indicator	Response
		Daily

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

Number	Indicator	Response
E.IX.1	**BSS entity type** What type of entity was contracted to perform each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	**Wipro Infocrossing** Not Answered
E.IX.2	**BSS entity role** What are the roles performed by the BSS entity? Check all that apply. Refer to 42 CFR 438.71(b).	**Wipro Infocrossing** Not Answered